U.S. Department of Labor

Office of Administrative Law Judges
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In the Matter of

EugeneYates,
Claimant

v.

Virginia Pocahontas Company,
Employers

and

Director, Office of Workers' Compensation Programs,
Party-In-Interest

Date Issued: 3-08-01

Case No. 2000-BLA-202

Appearances:

Lawrence L. Moise, Esq.
For the Claimant

Mary Rich Maloy, Esq.
For the Employer

DECISION AND ORDER ON MODIFICATION
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

I have based my analysis on the entire record, including the transcript, exhibits, and representations of the parties, and have given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

Jurisdiction and Procedural History

The Claimant filed his initial claim for benefits on August 8, 1979 (DX 1). On June 5, 1987, Administrative Law Judge Gilday denied the claim. Judge Gilday found that the Claimant had thirty years and eleven months of coal mine employment; that the Employer was properly named as the responsible operator; and that the Claimant had one dependent for purposes of augmentation of benefits. Judge Gilday also found that the Claimant was entitled to the interim presumption pursuant to 29 C.F.R. § 727.203(a)(1), based on one positive x-ray, but that the Employer had established rebuttal pursuant to § 727.203(b)(3).

Judge Gilday's decision was affirmed by the Benefits Review Board (Board) on July 20, 1992, and by the Fourth Circuit Court of Appeals on October 19, 1993.

On May 23, 1994, the Claimant filed a request for modification (DX 125). Administrative Law Judge Amery denied this request on February 1, 1996, finding no change of condition or mistake of fact, and concluding that the presumption under § 727.203(b)(3) was still rebutted. He also found that the newly submitted x-rays were all negative, the newly submitted pulmonary function studies were invalid and non-qualifying, and the newly submitted arterial blood gas study results were non-qualifying.

On February 3, 1997, the Claimant filed a request for modification (DX 167). His claim was remanded to the Director on June 12, 1997, by Administrative Law Judge Murty, who ordered the Claimant to undergo a pulmonary evaluation. The claim was subsequently returned to the Office of Administrative Law Judges, and on January 21, 1999, Administrative Law Judge Donnelly issued his decision denying the Claimant's request for modification. Judge Donnelly found that the newly submitted evidence did not establish a mistake of fact in the previous determination that the Claimant's disability did not arise in whole or in part out of his coal mine employment, nor did it establish a change of conditions. Judge Donnelly affirmed the previous finding that rebuttal was established under § 727.203(b)(3).

Judge Donnelly noted that the Employer had requested reconsideration of the previous finding of invocation of the interim presumption under § 727.203(a)(1). Although he indicated that this issue was moot, he also noted that one positive x-ray reading was no longer sufficient to invoke the interim presumption; he found the weight of the newly submitted x-ray evidence, as well as all of the x-ray evidence of record, to be negative; and he agreed with Judge Gilday's April 1, 1991 determination that the weight of the evidence was negative for

pneumoconiosis.[1]

On June 30, 1999, the Claimant requested modification, which was denied by the Director on October 6, 1999 (DX 186). The Claimant submitted additional evidence by cover letter of October 15, 1999 (DX 188), and on October 20, 1999, the District Director again denied the request (DX 189). The Claimant requested a formal hearing and submitted additional medical evidence (DX 190, 193, 194), and his claim was forwarded to the Office of Administrative Law Judges on December 8, 1999 (DX 195-196).

A hearing in this matter was held on May 18, 2000, in Abingdon, Virginia. At the hearing, Director's Exhibits 1-196[2], Claimant's Exhibits 1-4, and Employer's Exhibits 1-17 were admitted to the record ((TR 5-11). The Employer's brief was received on August 3, 2000; the Claimant's brief was received on September 22, 2000.

Applicable Law

Applicability of New Regulations

On February 15, 2001, I issued an Order pursuant to the Preliminary Injunction Order issued by the United States District Court for the District of Columbia in *National Mining Association v. Chao*, directing that the parties submit briefs stating with specificity how application of the amended regulatory provisions at 20 C.F.R. §§ 718.104(d), 718.201(a)(2), 718.201(c), 718.204(a), 718.205(c)(5), or 718.205(d) would affect the outcome of this claim. On February 23, 2001, counsel for the Claimant submitted a response, stating that the Claimant believed the amended regulation (he did not specify which one) should apply in his case. On March 2, 2001, the Employer submitted a response, urging that several of the amended regulatory provisions could affect the outcome of this claim, and requesting a stay of this proceeding. On March 6, 2001, the Director filed a response, arguing that the new regulations will not affect the outcome of this case.

I note that neither the Claimant nor the Employer has complied with my February 15, 2001 Order; that

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[1] By a Decision and Order dated March 30, 1990, the Board remanded the claim to Judge Gilday to reconsider the Claimant's entitlement to benefits under 20 C.F.R. § 410.490. In his Decision and Order on Remand, issued on April 1, 1991, Judge Gilday found that the weight of the evidence did not establish the existence of pneumoconiosis by x-ray; and further, that the pulmonary function study evidence did not demonstrate the existence of a chronic respiratory or pulmonary disease, and thus the § 410.490 presumption was not triggered. Subsequently, on July 20, 1992, the Board noted that the Supreme Court, in *Pauley v. Bethenergy Mines, Inc.*, 111 S.Ct. 2524 (1991), held that a claim properly adjudicated under § 727.203 is not subject to adjudication under § 410.490. Finding that Judge Gilday had properly adjudicated this claim under § 727.203, the Board vacated Judge Gilday's Decision and Order on Remand, and reinstated his original Decision and Order denying benefits.

[2] The last page of Director's Exhibit 157 is not a part of the record in this case, as it pertains to an x-ray of someone other than the Claimant (TR 6).

is, they have not stated with specificity how the new regulations will affect the outcome of this proceeding, or discussed their potential application to any of the specific evidence in this case. The Claimant's entire argument is as follows: "Please be advised that Mr. Yates believes the amended regulation should apply in his case." The Employer's response discusses the regulations themselves, but does not refer to any specific evidence in this case.

Section 718.201(c)

The Employer argues that the new portion of the definition of pneumoconiosis contained at § 718.201(c) is a significant change that could affect the outcome of this claim. Section 718.201(c) states that: "'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." The Employer argues that "latent and progressive" is not included in the definition of pneumoconiosis in the Fourth Circuit, and that there are no Fourth Circuit black lung cases discussing such a concept. Thus, the Employer argues, this new regulatory definition "significantly alters the definition of coal workers' pneumoconiosis in a fundamental way," and that retroactive application of this new definition denies the parties due process of law. The Employer also argues that the holding of the Third Circuit Court of Appeals in *LaBelle Processing Co. v. Swarrow*, 72 F.2d 308, 315 (3rd Cir. 1995), that pneumoconiosis is a progressive or latent disease, is *obiter dicta* which has not been adopted by the Fourth Circuit.

The Director argues that the Fourth Circuit has in fact expressly recognized the latent and progressive nature of pneumoconiosis. *See, Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Lane Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1998); *Adkins v. Director, OWCP*, 958 F.2d 49, 51 (4th Cir. 1992); *Greer v. Director, OWCP*, 940 F.2d 88, 90 (4th Cir. 1991); *Hamrick v. Schweiker*, 679 F.1d 1078, 1081 (4th Cir. 1982); *Prater v. Harris*, 620 F.2d 1074, 1082 (4th Cir. 1980); *Barnes v. Mathews*, 562 F.2d 278, 279 (4th Cir. 1977). Thus, the Director argues that the revisions to the definition of pneumoconiosis are consistent with controlling precedent in the Fourth Circuit, and application of the new regulation will have no effect on the outcome of this case.

As the Director correctly points out, there are Fourth Circuit cases that, while not specifically adopting the *LaBelle* rationale, hold that pneumoconiosis is a progressive disease, and strongly suggest that it can first become detectable after coal mine employment ceases.[3] In the most recent case cited by the Director, *Eastern*

[3] In arguing that "latent and progressive" is not included in the definition of pneumoconiosis in the Fourth Circuit, the Employer states that there are no Fourth Circuit cases that discuss such a concept, basing its argument on the results of its Westlaw search for cases after the *LaBelle* decision. I find this argument to be disingenuous, because the Employer performed its search using the word "latent," but not the word "progressive." Clearly the results of a search using both terms would have produced numerous cases that address the concept in question, if not with the precise term by which the Employer limited its search.

Associated Coal Corp. v. Director, OWCP, supra, the Court of appeals affirmed the finding of the administrative law judge that a miner whose coal mine employment ended in 1973 had complicated pneumoconiosis where his chest x-rays prior to 1970 were negative for pneumoconiosis, subsequent x-rays were positive for simple pneumoconiosis, and a February 1991 x-ray showed complicated pneumoconiosis. Similarly, in *Lane Hollow Coal v. Director, OWCP, supra,* the Court affirmed the finding of the administrative law judge that a miner who retired in 1975 had pneumoconiosis where the x-rays from 1974-1980 were negative for pneumoconiosis, but the x-rays from 1981-1985 were positive for pneumoconiosis.

Nor do I agree with the Employer that the holding in *LaBelle* is dicta. Indeed, there are many decisions by administrative law judges applying this holding in cases arising in the Fourth Circuit to discredit the opinions of physicians who insist that a miner cannot develop pneumoconiosis if he does not have it when he leaves the mines; yet there are no cases from the Fourth Circuit, or any other circuit, that repudiate this holding. I find that § 718.201(c) does not expand the definition of pneumoconiosis in the Fourth Circuit. But even if it did, the Employer has not pointed to any specific evidence in this case that would be affected by this new regulation. I find that the application of § 718.201(c) would not affect the outcome of this case.[4]

Section 718.104(d)

The Employer argues that because the Claimant's claim includes reports and testimony from a treating physician, the presumption to be given to such evidence at § 718.104(d) may apply, and that retroactive application of this provision is not appropriate. The new § 718.104(d) provides that:

> In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

The Employer does not articulate precisely how this new regulation will change the outcome in this case. In fact, this new regulation does not provide for an evidentiary preference for the opinion of a treating physician, but merely allows the administrative law judge to give more weight to a treating physician's opinion, provided she considers its reasoning and documentation, other relevant evidence, and the record as a whole. This is entirely consistent with existing law, which allows the administrative law judge to accord more weight to the opinion of a treating physician, as long as she considers the credibility of the opinion in light of the evidence of record. *See Lango v. Director, OWCP,* 104 F.3d 573, 577 (3rd Cir. 1997). More importantly, this new regulation applies only to the opinions of treating physicians developed after January 19, 2001, the effective date of the new

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[4] The Employer argues retroactive application of this "new" regulatory definition denies the parties due process of law. However, if the new regulations do not affect the outcome of the case, it makes no difference if they are applied retroactively.

regulations. As the Director points out, no party has submitted any medical evidence that was developed after January 19, 2001.

Section 718.204(a)

Finally, the Employer argues that the change in § 718.204(a) could also affect this case, although again the Employer does not specify precisely how this change will affect the evidence or analysis in this case. Section 718.204(a) states:

> [a]ny nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

The Employer argues that this new regulation is inconsistent with the statutory requirement at Title 30 U.S.C. § 923(b) that all relevant evidence must be considered in a black lung claim. In fact, there is nothing in the new regulation that requires that relevant evidence be excluded from consideration. Instead, it simply follows the well established principle that nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. *See Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corporation & Triangle Enterprises*, 49 F.3d 993 (3rd Cir. 1995). I find that this new regulation would not affect the outcome of this case.

As I have determined that the new regulations will not affect the outcome of this case, the Employer's request that the proceeding be stayed is denied.

Nature and Scope of Modification Proceeding

In evaluating a modification request based on an alleged change in conditions, an administrative law judge is required to undertake a *de novo* consideration of the issue by first independently assessing the newly submitted evidence to determine whether it is sufficient to establish the requisite change in conditions. If a change is established, the administrative law judge must then consider all of the evidence of record to determine whether the claimant has established entitlement to benefits on the merits of the claim. *Kovac v. BNCR Mining Corp.*, 14 B.L.R. 1-156 (1990, *modified on reconsideration*, 16 B.L.R. 1-71 (1992).[5] *See also, Nataloni v.*

[5] In its decision on reconsideration, the Board modified its holding in *Kovac* by stating that new evidence is not a prerequisite to a modification based on an alleged mistake in a determination of fact; rather, "[m]istakes of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on the evidence initially submitted." *Id.* at 73.

Director, OWCP, 17 B.L.R. 1-82 (1993) and *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-8 (1994). In *Kingery*, the Board, citing its decisions in *Kovac* and *Nataloni*, described the proper scope of the *de novo* review of a modification request as follows:

> [A]n administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Id. at 11.

The Board has also held that the Administrative Law Judge should always review the record on modification to assess whether a mistake of fact has occurred. In determining whether a mistake of fact has occurred, the Administrative Law Judge has broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted. *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

Applicability of 20 C.F.R. § 727

As the initial claim for benefits was filed before December 31, 1979, this claim will be adjudicated under the interim regulations found at 20 CFR Part 727. Section 727.203 provides a claimant with 10 or more years of coal mine employment a rebuttable presumption of total disability due to pneumoconiosis if the claimant either establishes the existence of pneumoconiosis by chest roentgenogram, biopsy or autopsy; or establishes the presence of a chronic respiratory impairment through qualifying ventilatory studies; or demonstrates the presence of an impairment in the transfer of oxygen from the lung alveoli to the blood through qualifying values on blood gas studies; or establishes the presence of a totally disabling respiratory or pulmonary impairment through other medical evidence, including the documented opinion of a physician exercising reasoned medical judgment. 20 CFR § 727.203(a). In order to invoke the interim presumption, the Supreme Court has held that the claimant must prove one of these elements by a preponderance of the evidence. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135 (1988). If the presumption is invoked, the presumption may be rebutted through one of four means: evidence which establishes that the claimant is currently engaging in his usual coal mine work or other comparable gainful work; evidence which establishes that the claimant is able to do his usual coal mine work or other comparable gainful work; evidence which establishes that the claimant's total disability or death did not arise in whole or in part out of coal mine employment; or evidence which establishes that the claimant does not have pneumoconiosis. 20 CFR § 727.203(b).

Issues

The following issues are contested by the Employer and the Director:

1. Whether the Claimant has pneumoconiosis;

2. Whether the Claimant's pneumoconiosis arose out of his coal mine employment;
3. Whether the Claimant is totally disabled;
4. Whether the Claimant's total disability is due to pneumoconiosis.

(DX 195; Tr. 7-9). The Employer does not dispute Judge Gilday's finding that the Claimant had thirty years and eleven months of coal mine employment (Tr. 7).[6] Nor does the Employer dispute its status as the responsible operator, or the fact that the Claimant has one dependent, namely his wife, for purposes of augmentation of benefits (Tr. 19-20).

The Claimant's Testimony

The Claimant is 73 years old. His wife is his only dependent; all of his children are on their own. All of the Claimant's coal mine employment occurred in Virginia or West Virginia; he has not worked since leaving Island Creek in 1980. The Claimant has never smoked. He first began to notice breathing problems in 1974, specifically, shortness of breath and chest pain; he attributed the problems to his coal mining. Since the last hearing in this matter, the Claimant's breathing has gotten worse, and his chest feels like it is "closing off." He has pain in his shoulder blades and the top of his chest. He can walk only 50 to 75 feet before having to stop, and walking and going up and down steps cause shortness of breath. The Claimant has been seeing Dr. Thakkar since 1980, and Dr. Patel for two or three years. He is currently taking "puffers," breathing pills, Coumadin, and heart medication. (Tr. 13-19).

The New Medical Evidence

The following newly submitted medical evidence is in the record.

X-ray Evidence

Exhibit	***Date of Film***	***Date of Reading***	***Physician/ Qualifications***[7]	***Impressions***

[6] DX 195 indicates that the Director agrees that the Claimant has established 30.90 years of coal mine employment.

[7] A "B-reader" is a physician, but not necessarily a radiologist, who has successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" means that the physician is "certified" in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

DX 194	9/24/99	9/27/99	Patel	no acute cardiac, pulmonary or pleural pathology
DX 185	9/14/99	9/17/99	Wheeler/BCR,B	no parenchymal or pleural abnormalities consistent with pneumoconiosis.
DX 185	9/14/99	9/20/99	Scott/BCR,B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
EX 7	9/14/99	3/17/00	Wiot/BCR,B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
DX 188	7/6/99	7/7/99	Weaver	ill-defined, mass like density or infiltrate right lower lung. Possible pneumonitis in central area of concentrated density.
DX 179	5/7/99	6/26/99	Capiello/BCR,B	1/2, p/q, category O opacities
DX 179	5/7/99	6/17/99	Aycoth/B	1/1, p/p, category O opacities
DX 179	5/7/99	6/11/99	Pathak/B	1/1, p/q
DX 184	5/7/99	7/24/99	Alexander/BCR,B	1/1, p/p
CX 3	5/7/99	3/21/00	Robinette/B	0/1, q/t, category O opacities
DX 83	2/9/99	8/20/99	Barrett/ BCR/B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
EX 3	2/9/99	12/20/99	Wiot/BCR, B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
EX 4	2/9/99	12/31/99	Meyer/BCR, B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
EX 4	2/9/99	1/20/00	Spitz/BCR,B	no parenchymal or pleural abnormalities consistent with pneumoconiosis
DX 188	2/9/99	2/9/99	Patel	prominence of the bronchovascular markings and interstitial markings
DX 188	7/12/98	7/13/98	Patel	stable chest
DX 188	10/23/97	10/23/97	Patel	no acute cardiac, pulmonary, or other pleural pathology

CX 2	4/15/84	6/24/86	Robinette/B	1/1, q/t, right middle lobe density consistent with either atelectasis of right middle lobe or coalescence of pneumonic nodules, diffuse interstitial fibrosis

Medical Opinions

Dr. M.J. Thakkar

On May 20, 1999, Dr. Thakkar wrote a one page report, in which he indicated that the Claimant had a 34 year coal mine employment history, and suffered from shortness of breath and orthopnea, as well as episodes of paroxysmal nocturnal dyspnea (DX 176). He also noted that the Claimant had a myocardial infarction in 1980, and triple vessel bypass surgery in 1980 and 1989. Dr. Thakkar indicated that he was treating the Claimant for arteriosclerotic heart disease, coal workers' pneumoconiosis, ventricular tachycardia, congestive heart failure and LV dysfunction. He noted that the Claimant had been admitted to the hospital on multiple occasions for bronchitis and bronchial spasm, and that a February 9, 1999, x-ray showed prominent bronchovascular markings and interstitial lung markings. Dr. Thakkar believed that the Claimant had coal workers' pneumoconiosis based on his mining history, his shortness of breath, and his recurrent bronchitis and bronchospasm. He further indicated that the Claimant was totally disabled from any employment.

On August 16, 1999, Dr. Thakkar wrote a second report, the full text of which is as follows (DX 184):

> Mr. Eugene Yates is under my care for ASHD, s/p CABG, congestive heart failure, hypertension, COPD. Due to the condition of Mr. Yates heart, I do not recommend that he have a treadmill stress test or any pulmonary function test, such as ABG, PFT. Mr. Yates was put through these test before and ended up having to go to the hospital because of chest pain. In the event you should require any further information concerning the health status of Mr. Yates. Please contact my office. Thank You.

On February 22, 2000, Dr. Thakkar wrote that he was treating the Claimant for "ASHD s/p coronary artery bypass surgery times two, poor LV function causing CHF, COPD, hypertension." He recounted the Claimant's medical history. Dr. Thakkar stated:

> It is my professional opinion that Mr. Eugene Yates does suffer from pulmonary impairment that arises out of his coal mine employment and does contribute to his inability to return to his previous coalmine work. Mr. Eugene Yates is permanently and totally disabled to engage in any type of employment due to his severe lung and heart problems.

(CX 1).

On March 23, 2000, Dr. Thakkar reported that the Claimant was hospitalized on March 7, 2000, for

"frequent episodes of chest pain in both axillary areas radiating to both shoulders and all across the anterior chest, epigastric area which felt like tightness." The Claimant also had shortness of breath and nausea. The Claimant reported experiencing shortness of breath, tightness in the chest, and dizziness when he tried to walk or engage in other activity. Dr. Thakkar recommended that the Claimant not be subjected to pulmonary function tests, as he had experienced chest pain in the past while undergoing this test (CX 2).

Dr. G.J. Patel

Dr. Patel prepared a report dated May 28, 1999, in which he noted that the Claimant had a known history of atherosclerotic heart disease, status post CABG, CHF, COPD and coal workers' pneumoconiosis (DX 176). The Claimant's conditions had been managed on anti-anginal medications, cough syrup, and inhalers. He noted that eighteen years ago, the Claimant developed progressive shortness of breath with recurrent cough. He now has difficulty walking distances and climbing stairs because of this shortness of breath. He has been hospitalized for acute bronchitis and unstable angina. Dr. Patel noted that the Claimant's pulmonary function tests showed moderate "OAD" based on reduced FEV1. He noted the Claimant's thirty four year mining history, and that the Claimant had not smoked in the past. According to Dr. Patel, the Claimant's chest x-ray showed increased interstitial lung markings and mild cardiomegaly. Dr. Patel concluded that the Claimant had recurrent bronchitis and significant ventilatory impairment. He further noted that with no previous history of smoking and with prolonged exposure to coal dust, it was highly likely that coal dust exposure caused the ventilatory impairment. In his opinion, the Claimant was totally and permanently disabled, and unable to return to his previous mine work.

Dr. Roger J. McSharry

Dr. McSharry is board certified in internal medicine, pulmonary medicine, and critical care medicine. He examined the Claimant on September 15, 1999, and prepared a report dated September 23, 1999 (DX 185). Dr. McSharry recorded the Claimant's medical, social, family and occupational history, and performed a physical examination and review of systems. The Claimant's EKG showed a sinus rhythm with left axis deviation, old anterior wall myocardial infarction evidence, and frequent premature ventricular contractions, which were new from 1995. His chest x-ray showed cardiac enlargement with probable pulmonary edema, but no pneumoconiosis. Dr. McSharry noted that Dr. Wheeler found no pneumoconiosis on the x-ray. The Claimant did not undergo arterial blood gas studies or pulmonary function tests on the advice of his cardiologist, Dr. Thakkar. The Claimant had been hospitalized within a week of this September 15, 1999, examination, four days of which were spent in intensive care.

Based on his examination and interview of the Claimant, Dr. McSharry felt that the Claimant had severe coronary artery disease, probable congestive heart failure and cardiac dysrythmias, and some degree of chronic bronchitic symptoms. He found no evidence of pneumoconiosis, but noted that his evaluation was limited due to the absence of pulmonary function and arterial blood gas data. Dr. McSharry based his impression on the lack of typical radiographic abnormalities seen on the Claimant's chest x-ray.

With regard to the Claimant's pulmonary condition, Dr. McSharry stated that most of his symptoms could be accounted for by the Claimant's cardiac dysfunction; shortness of breath with walking, shortness of breath when recumbent, peripheral edema, and wheezing all can be seen in congestive heart failure and cardiac dysfunction without any underlying lung disease. Without the pulmonary function tests, he could not determine the existence of respiratory impairment, since the presence of symptoms did not necessarily imply impairment.

Dr. McSharry also reviewed extensive medical records. He noted that pulmonary function tests were notably absent over the course of the Claimant's evaluations, but that the pulmonary function test done by Dr. Hippensteel, while not reproducible and possibly not representing the Claimant's best efforts, nevertheless provided results that could not be obtained in a patient with even mild obstructive or restrictive lung disease. The pulmonary function tests set a lower limit for the Claimant's lung function, ruling out significant obstructive or restrictive impairment. Dr. McSharry concluded that since there was no respiratory impairment demonstrated, there was no evidence that exposure to coal or coal dust caused respiratory limitation. However, he did feel that the Claimant had a severe disability based on his cardiac disease, which was unrelated to his coal dust exposure. This disability would prevent him from performing his last coal mine employment, but his degree of disability would have been the same if he had never been exposed to coal dust. If the Claimant was determined to have coal worker's pneumoconiosis, Dr. McSharry's opinion on the lack of respiratory impairment would not change.

Dr. Hippensteel

Dr. Kirk E. Hippensteel additional medical records, and prepared a report dated March 28, 2000 (EX 8). Based on his review of this evidence, Dr. Hippensteel concluded that the Claimant did not have coal workers' pneumoconiosis. He based this finding on the fact that most of the x-ray interpretations were negative and that the pulmonary function testing had not shown a loss of ventilatory or gas exchange reserve. The lack of loss of ventilatory or gas exchange reserve meant that even if the Claimant had pneumoconiosis, he did not have a permanent pulmonary impairment. Dr. Hippensteel believed that the Claimant was disabled based on his cardiac problems, and noted that his conclusions were generally the same as they had been in his prior report and deposition. He noted that there was no relationship between the Claimant's coronary artery disease and his coal dust exposure, and that in the medical literature, there is no association between coronary artery disease and coal workers' pneumoconiosis. He felt the Claimant would have been just as disabled had he never set foot in a coal mine.

Dr. Dahhan

Dr. A. Dahhan, who is board certified in internal medicine and pulmonary medicine and is a B-reader, reviewed the medical evidence, and prepared a report dated March 24, 2000 (EX 9). Based on this review and his prior examination of the Claimant, Dr. Dahhan concluded that there was insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis, based on the negative x-ray readings for pneumoconiosis, adequate pulmonary function studies when the Claimant produced valid spirometry, adequate blood gas exchange mechanisms at rest and after exercise during the period when the Claimant's congestive heart failure was not decompensating, and intermittent bronchospasms on clinical examination of the chest.

Dr. Dahhan further found that the objective data did not support a finding of either total or permanent pulmonary disability due to the inhalation of coal dust or coal workers' pneumoconiosis. Dr. Dahhan did feel that the Claimant had intermittent acute bronchitis, caused by infected bronchial pipes, and significant coronary artery disease; but these conditions were not caused by coal dust inhalation or coal workers' pneumoconiosis. He also concluded that even if the Claimant were found to have radiological evidence of pneumoconiosis, he would still find that the Claimant's disability was due not to pneumoconiosis, but to hardening of the arteries of the heart, a condition of the general public at large.

Dr. Morgan

Dr. W. K. C. Morgan reviewed medical records, and prepared a report dated April 3, 2000 (EX 9). He noted that in his review of the July 12, 1998, x-ray, Dr. Patel did not mention the presence of coal workers' pneumoconiosis. He also noted that the pleural thickening seen by various doctors on the May 7, 1999, x-ray, was not seen on the CT scan. Dr. Morgan indicated that pleural plaques would show up on a CT scan, and concluded that the Claimant actually had subpleural and axillary fat pads overlapping the chest wall, causing soft tissue shadows which mimic pleural plaques. Dr. Morgan questioned Dr. Aycoth's reading of the May 1999 x-ray, noting that in 1981, Dr. Aycoth found a greater profusion than in 1999.

Dr. Morgan questioned Dr. Patel's reliance on the FEV1 result to show obstructive airways disease, because a reduced FEV1 can be the result of lack of effort, and can indicate a restrictive impairment as well.

Dr. Morgan found no radiographic evidence of coal workers' pneumoconiosis. He noted that although the Claimant had apparently been considered to be a nonsmoker, Dr. Zaldivar indicated that the Claimant smoked less than a package of cigarettes a day for four or five years. Dr. Morgan also noted that the Claimant's brother died from lung cancer; as cigarette smoke is virtually the only cause of lung cancer, he assumed that the Claimant's brother smoked, and that it would be uncommon to find two brothers who grew up together, with only one smoking. He also speculated that smoking contributed to the Claimant's cardiac disease, although he conceded that nonsmokers occasionally develop such disease.

Dr. Morgan did not believe the Claimant had any pulmonary impairment. He felt that the Claimant's congestive heart failure may have caused a temporary restrictive defect, but it was unrelated to coal mining. He also noted that the Claimant's overweight nature could cause a mildly reduced ventilatory capacity and hypoxemia. Dr. Morgan felt that the Claimant is permanently and totally disabled due to his heart disease and age, and could not perform his former coal mining work, an opinion that would not change if the Claimant were determined to have coal workers' pneumoconiosis. According to Dr. Morgan, it would be difficult to diagnose pneumoconiosis in the face of a completely negative CT scan.

Medical Records from Buchanan General Hospital

The Claimant was admitted to the hospital on October 23, 1997, complaining of chest pain of a couple of weeks' duration. His history included known arteriosclerotic heart disease, with a 1980 anterior wall myocardial

infarction; he had twice undergone cardiac catheterization and triple vessel bypass surgery. The Claimant was admitted; his EKG and cardiac enzymes studies showed no evidence of an acute myocardial infarction. He was discharged on October 27, 1997, when his condition stabilized. His primary diagnosis was unstable angina pectoris, controlled.

The Claimant was admitted to the hospital on July 2, 1998, complaining of chest pain and shortness of breath. He was admitted for treatment of his angina, and to rule out a myocardial infarction. A July 6, 1998, chest x-ray showed an ill-defined mass-like density or infiltrate in the right lower lung, with possible distal pneumonitis from the central area of the concentrated density. The Claimant underwent procedures to rule out a pulmonary embolism. During this admission, the Claimant also underwent a CT scan of the thorax to rule out a right lower lung mass. Dr. John A. Weaver found no solid mass, and no abnormal pleural findings. A later chest x-ray on July 12, 2000, showed a stable chest. The Claimant was discharged on July 13, 1998, with primary diagnoses of unstable angina pectoris, controlled, and right lower lobe pneumonia, resolved.

The Claimant was admitted to the hospital on February 9, 1999, with complaints of cough, shortness of breath, and tightness in the chest lasting two weeks (DX 188). His admission diagnosis was acute bronchitis and bronchospasm. In the course of the physical examination, the physician found an emphysematous chest with scattered rhonchi and wheezing throughout the chest. The Claimant was given antibiotics and bronchodilators. He was discharged on February 22, 1999, when his condition stabilized. His primary diagnosis on discharge was acute bronchitis and bronchospasm, controlled.

The Claimant was again admitted to the hospital on September 2, 1999, with a chief complaint of intermittent chest pain for two days. The Claimant's EKG and cardiac enzyme study were negative for acute myocardial infarction. He was discharged on September 10, 1999, with primary diagnoses of unstable angina pectoris, acute bronchitis, and episodes of ventricular tachycardia, all of which were controlled.

On September 24, 1999, the Claimant was once again admitted to the hospital complaining of chest pain for one day, double vision lasting a week, intermittent dizziness, tightness and pressure in the substernal area radiating across the chest, shortness of breath, and nausea. On examination, Dr. Thakkar noted a mid systolic murmur at the apex and left sternal border area. He also found a moderately emphysematous chest, hyperresonant lungs on percussion, fair air entry, and occasional rhonchi. A color doppler examination of the carotid vessels taken on September 25, 1999, and read by Dr. Patel, showed atherosclerotic disease consistent with the Claimant's age, as well as mild stenosis. A CT scan of the head taken on September 24, 1999, was read by Dr. Patel as showing small lobe density areas scattered in the right parietal lobe, which he felt was probably from an old infarct. Cardiac enzyme studies and an EKG showed no evidence of an acute myocardial infarction. On September 30, 1999, the Claimant was discharged, although he still had a problem with double vision. His primary diagnoses were unstable angina pectoris, improved, and transient ischemic episode (DX 194).

Dr. Wiot

On November 23, 1999, Dr. Jerome F. Wiot, who is a board-certified radiologist, reviewed the July 8, 1998, CT scan and found no evidence of coal workers' pneumoconiosis. The only abnormality shown was evidence of previous coronary bypass surgery (EX 1).

Dr. Spitz

On December 8, 1999, Dr. Harold B. Spitz, who is a board-certified radiologist and B reader, reviewed the July 8, 1998, CT scan and found no evidence of coal workers' pneumoconiosis. He did find evidence of a previous CABG (EX 2).

Dr. Scott

On February 25, 2000, Dr. William W. Scott, Jr. reviewed the July 8, 1998, CT scan and found no evidence of silicosis or coalworkers' pneumoconiosis. He did find evidence of anterior chest surgery, which was probably coronary artery bypass (EX 5).

Dr. Wheeler

On February 28, 2000, Dr. Paul S. Wheeler reviewed the July 8, 1998, CT scan and found no pneumoconiosis. He found evidence of healed anterior chest surgery for coronary artery bypass with minimal arteriosclerosis in the left coronary and circumflex arteries, as well as a minimal arteriosclerosis aortic arch, minimal to moderate obesity, and a few tiny calcified granulomata in the lower pretracheal and bilateral hilar nodes, and one in the right lateral CPA compatible with healed tuberculosis or histoplasmosis. He also found a small discoid atelectasis or scar in the posteriomedial portion of the left lower lung (EX 5).

Dr. Fishman

On March 20, 2000, Dr. Elliot K. Fishman, who is a board certified radiologist, reviewed the July 8, 1998, CT scan (EX 6). He found very minimal scarring at the base of the lung fields, with evidence of prior cardiac surgery. He found no evidence of asbestosis, pneumoconiosis, or coalworkers' pneumoconiosis.

Discussion

In order to be entitled to modification, the Claimant must establish that there has been a change in conditions since the previous decision denying him benefits, or a mistake in determination of a fact in the previous denial decision.

I find that the newly submitted evidence, viewed in the context of the record as a whole, does not establish that there was a mistake of fact in the previous determination by Judge Donnelly that the Claimant's disability did not arise in whole or part out of coal mine employment. Nor does the weight of the newly submitted evidence establish a change in conditions since that determination. The preponderance of the evidence continues to show that the Claimant is disabled by his cardiac condition, but not from any pulmonary impairment.

Thus, Dr. McSharry examined the Claimant, although he was unable to perform pulmonary function or arterial blood gas testing because of the Claimant's heart condition. Nevertheless, based on the information he had, which included Dr. Hippensteel's negative x-ray reading, and non-qualifying pulmonary function study results, as well as the Claimant's extensive history of cardiac disease, Dr. McSharry found no objective evidence that the Claimant suffered from any pulmonary impairment.

Similarly, Dr. Hippensteel concluded that the Claimant is disabled due to his coronary artery disease, but that he does not have a disabling respiratory impairment. Dr. Hippensteel based his opinion on his negative reading of the Claimant's x-ray, as well as the results of the pulmonary function and arterial blood gas tests. Dr. Dahhan also concluded, based on the Claimant's negative x-ray, his non-qualifying pulmonary function study results when those tests were valid, and his arterial blood gas study results when the Claimant's heart condition was not causing him to decompensate, that there was no objective evidence to support a finding of total disability due to pneumoconiosis. Both Dr. Hippensteel and Dr. Dahhan noted that, even if the Claimant had pneumoconiosis, it was not causing a respiratory impairment. I find their conclusions to be well-reasoned and supported by the objective medical evidence.

Dr. Morgan concluded that there was no radiographic evidence of pneumoconiosis, and no evidence of pulmonary impairment. Other than the x-ray evidence, Dr. Morgan cited to no objective evidence to support his conclusion that there was no respiratory impairment, although he did take issue with Dr. Patel's findings on spirometry. Additionally, Dr. Morgan appears to believe that there must be positive findings on a CT scan before pneumoconiosis can be diagnosed, a belief that flies in the face of the well-established concept of "legal" pneumoconiosis. For these reasons, I do not accord Dr. Morgan's opinion any particular weight.

The Claimant's hospital records reflect that he has been hospitalized several times since the previous decision for treatment of his cardiac condition. These records do not reflect any diagnosis of chronic pulmonary impairment; at most, they reflect that on one occasion the Claimant was treated for acute bronchitis and bronchospasm, conditions which resolved.

Dr. Thakkar's brief reports document the Claimant's history of cardiac problems. He noted that the Claimant's February 9, 1999, x-ray showed prominent bronchovascular markings and interstitial lung markings; this same x-ray was interpreted as negative for pneumoconiosis by three dually qualified readers. Dr. Thakkar based his opinion that the Claimant had coal workers' pneumoconiosis on his mining history, his shortness of breath, and his recurrent bronchitis and bronchospasm. However, he did not cite to any objective studies that showed a permanent pulmonary impairment, or explain how the Claimant's shortness of breath was related to a respiratory impairment instead of his documented cardiac disease. Nor did he specifically relate the Claimant's total disability to a respiratory impairment, as opposed to his cardiac impairment.

In his brief report, Dr. Patel stated that the Claimant's pulmonary function tests have shown moderate "OAD" based on reduced FEV1 values. However, the valid pulmonary function study results of record

produced non-qualifying results. Nevertheless, Dr. Patel concluded that, based on the Claimant's x-ray (he did not specify which one) which showed increased interstitial lung marking and mild cardiomegaly, as well as the Claimant's history of coal mine employment, he has a significant ventilatory impairment, caused by his exposure to coal dust. However, Dr. Patel does not even mention the Claimant's well-documented cardiac disease as a possible cause of his symptoms. I find that Dr. Patel's conclusions are not well-reasoned, and they certainly are not supported by the objective evidence of record.

I find that the weight of the newly-submitted evidence establishes that the Claimant's disability did not arise in whole or in part out of his coal mine employment, and I therefore affirm Judge Donnelly's previous finding that rebuttal has been established under § 727.203(b)(3).

Although this issue is moot, I find that the weight of the newly submitted x-ray evidence is negative for pneumoconiosis, as is all of the x-ray evidence of record. I note that the newly submitted x-ray evidence includes seventeen readings of seven x-rays performed between 1997 and 1999.[8] The only positive readings were of the May 7, 1999 x-ray, which was interpreted as positive by four physicians. However, the three x-rays that were done before, as well as the three x-rays that were done after this particular x-ray were uniformly interpreted as negative, with numerous interpretations by B readers and dually qualified physicians.

Thus, for the above reasons, I find that the Claimant has not established a change of conditions since the previous denial by Judge Donnelly. Nor has he established a mistake in a determination of fact in that previous denial. The Claimant is not entitled to modification.

CONCLUSION

The Claimant, Eugene Yates, has not established that he has pneumoconiosis due to his coal mine dust exposure, or that he is totally disabled from a pulmonary condition.

ORDER

The claim of Eugene Yates for benefits under the Act is hereby DENIED.

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LINDA S. CHAPMAN
Administrative Law Judge

[8] I have not included the "new" positive interpretation of an April 15, 1984 x-ray by Dr. Robinette that was submitted by the Claimant (CX 2). In fact, this x-ray interpretation was previously considered by Judge Gilday in his April 1, 1991 Decision and Order denying benefits.